Sargent Shriver National Center on Poverty Law
Comments on Medicaid 1115 Draft Application
January 22, 2014

The Sargent Shriver National Center on Poverty Law respectfully submits the following comments on the Proposed "Path to Transformation" -- Medicaid and Children's Health Insurance Section 1115 Research and Demonstration Waiver. We have decades of experience representing Medicaid applicants and beneficiaries and deep expertise in Medicaid programs and, in particular, in the areas of eligibility, coverage, and access to care. Stephanie Altman, John Bouman, Andrea Kovach, and Margaret Stapleton, all attorneys at the Shriver Center, participate at all levels of the stakeholder process in Illinois including as longtime members of the Medicaid Advisory Committee and its various subcommittee, the Older Adult Services Advisory Committee, and the Balancing Incentive Program Advisory Committee. We have as a team a unique understanding of the issues of both the larger Medicaid population, including the newly-eligible adult population, as well as those with special needs who seek long term care services and supports. Based on our combined experience and expertise, and on behalf of the populations we serve, we provide the following comments on the proposal.

General Comments

Overall, we recommend that the State set forth a robust and transparent process for ongoing stakeholder engagement throughout the CMS review process and State implementation of the waiver, if approved. We commend the State on posting the concept paper and the draft waiver on the state agency websites as well as collaborating with a respected consumer organization with broad expertise in long term care services, the Health and Medicine Policy Research Group, to conduct a series of stakeholder meetings and solicit comment on the concept paper and proposal. We were pleased to see that hundreds of stakeholders attended the series of meetings held in the past three months to provide comments on behalf of their constituencies and submitted written comments to the State. In addition, many stakeholders attended the continuing legislative hearings on the waiver proposal, and consumer organizations and providers provided testimony to the committee. Lastly, we commend the state on including a discussion of the waiver concept paper at existing stakeholder committee meetings including at the Medicaid Advisory Committee, the Older Adult Services Advisory Committee, and the BIP Committee.

While these opportunities for stakeholder engagement and comment have taken place after the issuance of the Concept Paper and during the period of drafting the proposal, we recommend that the State continue and expand the stakeholder process throughout the discussions with CMS during the

review period and widely disseminate and publicize any subsequent changes to the proposed waiver program. Commonly, in the submission and approval of an 1115 waiver, there is a lengthy process of questions and answers between the State and the federal agency as well as revisions and refinements to the proposal. We recommend that the State, at a minimum, keep all current advisory committees informed of CMS questions and requests for additional information and responses from the State as well as any addenda, revisions, and refinements to the waiver proposal as these discussions take place. While advocates, providers, and consumers have an opportunity to communicate with CMS on their own, we recommend that a process that takes place in the State between stakeholders and the state agencies will demonstrate to CMS that the State is dedicated to extensive consumer and stakeholder engagement in the process. While federal regulations require opportunity for public notice and comment during the CMS review process as directed by CMS, we further recommend that the State continue and expand its own transparency and engagement process by keeping the public informed of changes and revisions and questions and answers posed by CMS and answered by the State.

Impact of the Recent issuance of Federal Home and Community Based Services Regulations

CMS issued final regulations for the HCBS program on January 10, 2014 (Federal Register January 16, 2014, Vol. 79, No. 11 at 42 CFR 430, 431 et al) describing and defining state plan section 1915i home and community based services under the Social Security Act as amended by the Affordable Care Act. The rule offers states new flexibilities in providing services to people with disabilities and older adults under 1915i, provides definitions of services and settings under the existing HCBS waiver programs, and further defines the Community First Choice State plan option. As this final rule was not issued until after the issuance of the Illinois 1115 Waiver proposal, we recommend that the State review the final regulations and ensure that the waiver proposal meets the definitions of HCBS in the regulation, especially with regard to creating a transition plan to meet the requirements for person-centered care and definitions of the characteristics of community settings to ensure that Illinois is in compliance. Also, we recommend that the State review the regulations to ensure that, in the planning of the Illinois 1115 waiver, the State is maximizing all opportunities to provide services to the entire Medicaid population in need, including targeted populations such as those who have substantial behavioral health needs, but do not yet meet the need for an institutional level of care as contemplated under the 1915i authority, so as to prevent and divert the need for acute and long term care thus maximizing federal funding and saving state dollars.

Pathway 1: Transform the Health Care Delivery System

To ensure continuity of care and reduce unnecessary emergency crises, we recommend that, in the process of proposed changes to the delivery system for Medicaid, the State pay particular attention to vulnerable populations being released from the Department of Corrections and moving from state facilities into the community.

At page 15, we suggest that the State expand the scope of service by the CCHHS to inmates being released from the Department of Corrections and returning to Cook County. These men and women need health care for all the same reasons that inmates of the Cook County jail and people released from

the jail do. CCHHS and DOC should cooperate with sharing of medical records and the scheduling of appointments following release by DOC to ensure care coordination and reduce emergency hospitalization. Similarly, the jail and the CCHHS should share medical records with DOC when jail inmates are sent to DOC post sentencing or upon parole revocation.

At pages 19 to 20, we suggest that the document specifically recognize that any downsizing, closing, or repurposing of health facilities will need to go through the Certificate of Need process of the Illinois Health Facilities Planning Board in order to make substantial changes. We also suggest that the State explicitly state how it will handle the transfer of residents from any facilities allowed to close, downsize, or repurpose to safeguard the well-being of facility residents and avoid or minimize transfer trauma.

Pathway 3: Workforce Development and Training Should Include Community Based Paraprofessionals

We commend the State on including increased resources, including loan repayment, training and Graduate Medical Education, to build the healthcare workforce necessary to meet the needs of the growing Medicaid population. We urge the State to continue to consider the existing network of safety net and community based providers already serving this population and making sure that they are included in any coordinated care and managed care network to ensure continued access to this experienced workforce. We urge the State to require managed care entities to contract with case managers, social workers, community health workers, peer counselors and other community based experts so as to capitalize on the workforce already dedicated to this population. We encourage the State to look at other types of incentives that could be used to build and retain a workforce of paraprofessionals that provide the types of wraparound services which support health outcomes. We also encourage the State to, while always being mindful of patient safety, be as open as permitted by federal and state law to allowing persons with criminal conviction records to join the health care work force and take advantage of assistance or incentives available to those without conviction records.

Pathway 4: Inclusion of Behavioral Health, Permanent Supportive Housing, Employment Supports and Case Management Needs in the Uniform Assessment Tool (UAT)

Since the process of development of the UAT has been ongoing throughout the Balancing Incentive Program (BIP) process, we urge the State to continue to include additional measures and assessments designed to understand an individual's needs specifically for behavioral health, housing and case management in the uniform assessment tool. The current HCBS waivers in Illinois have not traditionally provided an expansive and flexible array of services to address the social determinants of health – which is one of the stated reasons to create an 1115 waiver and to use a uniform method for determining the needs of the population and the flexibility to use Medicaid funding to provide the targeted services that can improve health outcomes. We commend the State in looking at this combined waiver authority as an opportunity to revise our current outdated and fragmented waiver system and to streamline the assessment and service delivery system. However, given that the State has not traditionally provided extensive and flexible behavioral health, permanent supportive housing, case management, and employment supports as a part of the Medicaid program, care will be needed to ensure that these supportive services are included in the design and implementation of the 1115 waiver. We urge the

State to also consider using the federal Targeted Case Management authority in combination or as an integral part of the waiver to better serve the needs of populations with chronic conditions. Case management can provide the tools to reduce barriers to care coordination such as transportation, access to housing, food assistance, energy assistance, supportive services, employment supports, income supports, child care assistance, medication management, and other services designed to encourage the use of health homes.

Flexibility to Use Innovative Models of Coordinated Care and Supportive Services

We recommend that the State explicitly include the opportunity for the waiver to incorporate best practices and models of care coordination that are currently be used in the design and implementation of Coordinated Care Entities and Accountable Care Entities in the design and implementation of the 1115 waiver. For example, one of the proposed CCEs for Medically Complex Children includes the promising practice of including a medical legal collaboration as a strategy to address the social determinants of health. These types of models should be included as a key strategy and funded service in the 1115 waiver to serve the Medicaid population.

Incentivize the entire system to provide flexible service not only managed care plans

We recommend that the State encourage and incentivize all providers including community based fee for service providers to provide flexible support services that improve health outcomes and reduce costs, even if these services are provided outside of a traditional managed care environment. We believe that there is a continuing role for case management, behavioral health, permanent supportive housing and other services which may continue to need to be paid through state line items in the budget, state grants and/or fee for service funds at least during the transition to managed and coordinated care. In the transition, we recommend that the State proceed carefully so as not to disrupt current access, care patterns, provider-patient relationships, or vital community and safety net supports. In particular, permanent supportive housing and case management are vital to this population to ensure care coordination and a stable health home.

Use of Managed and Coordinated Care

We commend the State on the multi-year effort to move Medicaid recipients into coordinated care environments, including health homes, in order to improve health outcomes and reduce unnecessary emergency care and cost. We are concerned, however, that in the negotiations around budget neutrality in an 1115 Waiver encompassing such an expansive population, that reliance on a capitated risk based managed care system that is very new to Illinois and still very much in progress may result in an underestimate or underfunded system that does not allow for the transition to managed care from a largely fee for service system and the importance of allowing community based provider- led coordinated care entities and accountable care entities the time that they need to be viable and provide care in the community. We urge the State to include detailed analysis of the current system that exists in Illinois in their discussions with CMS during the review period and incorporate the time and careful planning in the implementation of the waiver that is necessary for such a large transformation of the eligibility and delivery system.

Retroactive Eligibility, Section 1902(a)(34), 42 CFR 435.914

The State has requested permission to waive retroactive Medicaid eligibility for some populations to "mitigate institutional bias and provide equal opportunity to elect HCBS." While we support the stated aim of this provision, we are concerned that any waiver of retroactive eligibility will harm Medicaid recipients and increase the medical debt burden on consumers and providers. Retroactive eligibility is necessary for Medicaid recipients to be able to cover past medical costs in the community and in facilities. We urge the State to better explain the rationale behind the request for the waiver of this provision including specifically how it will reduce institutional bias; whether it will increase medical debt; whether it will harm individual consumers; and whether these aims can be accomplished in another manner.

Design and Cost Estimates

In the design and cost estimates of the waiver, we recommend that the State reinstate services such as dental care for adults which meet the aim of the waiver to provide preventive care and avoid unnecessary hospitalization and urgent care costs.

III. Approach to Evaluation

We commend the State on proposing a complex and far-reaching evaluation process. We encourage the State to look specifically at outcomes including health and behavioral health outcomes. We further encourage the State to build on the work done by the current evaluations of the Integrated Care Pilot in particular which includes robust measures for evaluating consumer choice and access.

Thank you again for this opportunity to submit comments. Please contact Stephanie Altman, stephaniealtman@povertylaw.org, or Margaret Stapleton, mstapleton@povertylaw.org, with any questions.

Respectfully submitted,

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